Developing a National Mental Health and Suicide Prevention Monitoring and Reporting Framework - online consultation survey

How to complete the online consultation Please allow around 20 minutes to complete the online consultation. All of the questions are optional, unless indicated. 1) The National Mental Health Commission will not publish individual responses, however de-identified information (for example quotes and aggregated results) may be used in National Mental Health Commission publications or on its website.

Do you consent to your responses being used by the National Mental Health Commission for this purpose?*
(✓) Yes
( ) No

Your information

2) Please provide your name: XXX

3) Are you completing this survey on behalf of an organisation? Yes

4) If yes, please provide the name of your organisation: Dietitians Association of Australia (DAA)

5) Please describe the perspective you represent today of the following options (choose one or more):
· Academic
· Carer
· Consumer
· Government
· Health professional
☑ Representative body
· Service provider
Other (please specify)

Domains

The image on Page 2 lists the potential domains for the Commission to monitor and report on. Note there are **social, system, and population domain categories**. The proposed domains align to four reform priorities:

- the Fifth National Mental Health and Suicide Prevention Plan
- the Contributing Lives Framework
- the National Disability Insurance Scheme (NDIS)
- the establishment of Primary Health Networks (PHNs).

Identified in the Framework in bold are priority reform areas proposed for monitoring and reporting over the next five years (2018 – 2022). Depending on policy directions, reform progress and changing areas of focus, additional domains may become priority areas for monitoring and reporting at a later stage. Domains with a * indicate areas for future development, likely for 2023 onwards. You can find more information on domains in Chapter 6, 7, and 8 of the consultation materials by accessing this link:
<https://drive.google.com/open?id=0B3MBdkCcuMtebkFPS3J3WmtHSFE>

6) What are the key **social domains** for the Commission to report on in mental health and suicide prevention?

Housing and homelessness are key social domains. Adequate housing with facilities for storage and preparation of nutritious food is essential to supporting physical and mental health.

Economic factors are also key to successful outcomes in mental and physical health. Adequate income is needed for food and nutrition security, which in turn supports physical and mental health and wellbeing.

7) What are the highest priority **social domains** for the next 5 years?

8) What are the key **system domains** for the Commission to report on in mental health and suicide prevention?

DAA considers it important to ensure **allied health services/supports** are included in the 'System Domains'. Several allied health professions (e.g. dietitians, exercise physiologists, psychologists) play an important role in providing care to improve the mental health, physical health and wellbeing of people with mental illness. The monitoring and reporting of allied health services/supports to people with mental illness should be strengthened in the monitoring and reporting framework for 'System Domains'. DAA suggests addressing this in the six points under 'System Domains' (pg: 11 of the consultation paper) that the framework will monitor and report on.

9) What are the highest priority **system domains** for the next 5 years?

ACCESSIBILTY AND EQUITY:

DAA agrees all four priority domains outlined in the consultation paper are important. However, under the domain of 'Accessibility and Access', DAA considers it important to **monitor and report on availability of and access to both physical health and mental health supports for people experiencing mental illness.** The high rates of physical illness including diabetes, respiratory illness, cardiovascular disease and cancer among people with serious mental illness are well documented. For example, people with serious mental illness are two to three times more likely to suffer from diabetes and the rate of cardiovascular disease is almost four times that of the general population[1, 2]. Depression is considered an independent risk factor for coronary heart disease, but can also affect the recovery of people with coronary heart disease and increase their risk of further heart problems[3].

The high level of comorbidity with chronic disease contributes to poor quality of life and is acknowledged as one of the major reasons for the high mortality and morbidity rates among people with serious mental illness. For example, the relative risk of death is estimated to be 2.2 times higher in people with mental disorders compared to the general population[4], and this is primarily due to chronic physical rather than mental illness[5].

The poor physical health of many people living with mental illness is due, in part, to the side effects of medication, a range of lifestyle factors, and inadequate management of chronic disease. Importantly, lifestyle factors such as poor diet, low levels of physical activity, smoking, and substance misuse are modifiable and offer a way for health professionals to assist people living with mental illness. The provision of multi-disciplinary care to address modifiable lifestyle factors is therefore an important component of holistic care for many people with mental illness and can improve both their physical and mental health outcomes.

Healthy eating behaviours, regular physical activity, moderate alcohol consumption, and smoking cessation can help decrease the burden of chronic disease[6]. When incorporated with evidence-based psychological and medical treatment, physical health supports such as **dietary and exercise interventions** can provide a range of physical, social and mental health benefits for people living with a mental illness.

The Dietitians Association of Australia endorses:
• Increased access to dietary and exercise interventions in addition to evidence-based psychological and medical treatment for individuals experiencing mental illness.
• Regular screening and ongoing monitoring of both physical and mental health for people experiencing mental illness.
• Where indicated, referral to appropriately qualified allied health professionals to address lifestyle issues and physical health needs.
• Strengthening referral networks and collaboration between core professionals in the mental health treatment team.

Given that physical health is a major concern among people with mental illness, DAA recommends expanding the priority domain of **'Accessibility and Equity' (page: 11, first bullet point)** to include physical health supports, as follows:

- *The availability of both mental health supports and physical health supports for people with mental illness across different geographical regions and demographics.*

CAPABILITY:

Mental health workforce education is an important system domain for the Commission to report on, especially with respect to education in the vocational education sector. Nutrition is a fundamental contributor to the mental and physical health of people with mental illness and thus mental health workers needs to be armed with basic food and nutrition knowledge and skills to support people with mental illness, as well as be equipped with skills to identify when to refer a patient to a relevant health professional for higher level care (in this case an Accredited Practising Dietitian). DAA is aware that a graduate of a Certificate III or IV may not have studied nutrition in their course. Therefore, monitoring should address the capacity of the vocational education sector to build the mental health workforce. For example, baseline and ongoing data should ideally be collected on the number of vocational education courses which address mental health, and which are adequately constructed to prepare mental health support workers for their work in the mental health sector.

References:

1. Australian Health Policy Collaboration, The Costs and Impacts of a Deadly Combination: Serious Mental Illness with Concurrent Chronic Disease. A Policy Issues Paper for: The Royal Australian and New Zealand College of Psychiatrists. 2016.
2. Morgan, V, et al., National survey of people living with psychotic illness 2010., in Commonwealth of Australia 2011: Canberra.
3. Beyond Blue and National Heart Foundation. Fact sheet: Coronary heart disease, anxiety and depression. 2011 [cited 2016 13 July]; Available from: https://www.heartfoundation.org.au/images/uploads/publications/Beyondblue_depression_CHD.pdf
4. Walker, E., R. McGee, and B. Druss, Mortality in mental disorders and global burden of disease implications. A systematic review and meta-analysis. JAMA Psychiatry, 2015. 72(4): p. 334-41.
5. Lawrence, D., K. Hancock, and S. Kisely, The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. British Medical Journal 2013. 346.
6. World Health Organisation, Global action plan for the prevention and control of noncommunicable diseases 2013-2020. 2013, WHO: Geneva, Switzerland.

10) What are the key **population domains** for the Commission to report on in mental health and suicide prevention?

Given nutrition is a key contributor to mental and physical health of people with mental illness, it is important that future Australian Health Surveys (including food and nutrition components) by the Australian Bureau of Statistics collect and analyse data in relation to food and nutrition, physical and mental health of people with mental illness.

11) What are the highest priority **population domains** for the next five years?

Given the high rates of physical illness, including diabetes, respiratory illness, cardiovascular disease and cancer among people with serious mental illness, DAA considers it vitally important to prioritise, monitor and report on the long-term health conditions and the mortality gap for people with mental ill health (as outlined under the Mental Health Outcomes, pg: 14), as well as the avoidable hospitalisations for physical illness in people with mental ill health (as outlined under the Broader Quality of Life Outcomes, pg: 14).

Mental health and physical health are fundamentally connected. A proportion of individuals experiencing mental illness will also experience poor physical health, and poor physical health can in turn be associated with poor mental health. Given the well-known relationship between physical and mental health, an increased focus on holistic multidisciplinary treatment can enhance quality of life, and improve the physical and mental health outcomes for individuals living with a mental health disorder.

Priority groups

Priority groups will be specifically monitored and reported on. Due to levels of need, difficulties with service access or other concerns, these priority groups require a specific focus to supplement broader monitoring and reporting on the mental health status of the general population.

The image on Page 2 lists the priority groups for the Commission to report on.

You can find more information on priority groups in Chapter 9 of the consultation materials by accessing this link: <https://drive.google.com/open?id=0B3MBdkCcuMtebkFPS3J3WmtHSFE>

12) Who are the priority groups the Commission should monitor and report on?
DAA agrees with the five priority groups identified in the consultation paper. However, given the higher rates of suicide and alcohol misuse among people living in rural and remote areas compared to urban areas, **DAA recommends including rural and remote populations in the priority list**, such that they are specifically monitored and reported on over the next five years.

13) Priority groups are aligned to priority reform areas: the Fifth National Mental Health Plan, the Contributing Lives Framework, the National Disability Insurance Scheme and the establishment of primary health networks. Are any groups missing in each of the priority reform areas?

14) Which of these groups are the highest priority for the Commission to monitor and report on in the next 5 years?

Opportunities for the Commission to add value through analysis

The table below outlines a number of opportunities for the Commission to add value through analysis. **Opportunity**	**Detail**
The Commission should leverage the Framework to guide further data linkage activities to link existing datasets	Many experts and organisations in the mental health and broader health system recognise the potential for data linkage to increase the value of existing data. The Commission has previously explored data linkage activities with the Australian Bureau of Statistics (ABS). The Framework could aim to strategically guide future linkage activities promoting further efforts to link existing datasets (including housing, ageing, disability, labour force, private health insurance, and mental health service provision).
The Commission should encourage others to address data gaps and linkage	As a secondary user of data, the Commission could enhance monitoring and reporting on mental health and suicide prevention through working with data custodians to consider further work to utilise longitudinal data, cross-sectional data, qualitative data, consumer and carer data, and outcome data. The Commission could also consider commissioning other organisations to directly address priority data gaps and explore data linkage.
The Commission should add value by analysing data at a national, jurisdictional and sub-jurisdictional level as appropriate	The Commission will provide an aggregated national picture of mental health and suicide in Australia, but can also provide information on what is occurring at the jurisdictional and sub jurisdictional levels. This analysis could serve to provide comparisons, highlight areas of best practice, as well as identify opportunities to drive improvements at the regional level.

The Commission should use unique primary data sources	There may be opportunities for the Commission to use unique, technology-enabled data sources to support future monitoring and reporting. These data sources may include social media data and google search analytics. These potential data sources will be explored and assessed further once the draft Framework is finalised. Further, a majority of data analyses in the current monitoring and reporting landscape focus on quantitative data. The Commission could include qualitative analyses and case studies including stories of lived experiences from consumers, carers, families and support people.

15) How can the Commission add value to existing analysis of mental health and suicide prevention data?

The Commission should seek the assistance of the Australian Health Practitioner Regulation Agency and the National Alliance of Self Regulating Health Professions in obtaining data about the activities of registered and self-regulated professionals in supporting people with mental health. This also applies to the collection of workforce data and the development of initiatives to develop the mental health workforce.

Flexible reporting

There is a range of monitoring and reporting formats that the Commission can use to appeal to different audiences. Please see some examples in the table below. **Media release:** overview of key information	**Topical reports (online/hard copy):** provides detailed findings on specific topics within mental health and suicide
Visuals and infographics (online/hard copy): to help communicate findings through social media	**Annual report (online/hard copy):** provides detailed findings
Videos: auditory and visual way to convey insights from analysis and reports	**Data cube:** Downloadable data that allows data manipulation and personal use
Interactive data: allows users to customise their own graphs	**Technical note:** describes the method and technical terms used in reports

16) What types of reporting formats would be helpful to you/your organisation?

The reporting formats that would be most help to our organisation (the Dietitians Association of Australia) include:

- Topical reports (online version)
- Interactive data
- Visuals and infographics

Any further comments

17) Please provide any further comments on the potential features of the Commission's framework for monitoring and reporting on mental health and suicide prevention.

Thank you and next steps

Thank you for your feedback.

We will consider your suggestions as we refine the Framework. Following a national consultation process, Nous and the Commission will refine and finalise the Framework by early 2018.

Should you or your organisation require further information to assist in understanding anything, please contact Nous Group at nhmc.mrf@nousgroup.com.au.

Further information about the National Mental Health Commission and its current projects may be found at: http://www.mentalhealthcommission.gov.au/